Home Health Agency
Annual Statistical Report
January 1 through December 31, 2010

The Annual Statistical report is not optional; all home health agencies are required to submit this data.

Please read all instructions before completing this report.

Responses are DUE by January 31, 2011

Submit this 2010 Home Health Agency Annual Report electronically to:
HomeHealthProviders@dhss.mo.gov

After the Bureau of Home Care & Rehab Standards receives the data the information will be sent to the Missouri Alliance for Home Care to be compiled into the annual report.

Bureau of Home Care & Rehabilitative Standards will only accept Home Health Agency Annual Report Electronically!

HOME HEALTH AGENCY ANNUAL REPORT
DEFINITIONS AND INSTRUCTIONS

PLEASE READ THESE INSTRUCTIONS BEFORE COMPLETING THE ANNUAL REPORT. All information given in this Annual Report should be for services rendered to patients in Missouri. Please do not include data on patients residing in states other than Missouri.

GENERAL DEFINITIONS

- **Agency Name and Address -** (reported on page 1) - List only the name and location of the **licensed** agency in Missouri for which this data is reported. Do not list the home office/ corporate headquarters if that is not the licensed agency submitting this data.

- **County -** (listed on page 1) - Please list the one county **in Missouri** where the parent office of the agency is located. Please refer to the county codes listed on the last page of these instructions. Enter the appropriate three-digit code on page 1 of the Annual Report.

- **Number of Branch Offices -** List the total number of branch locations of the agency as of December 31 of this report year.

- **CMS Certification Number (CCN) -** Enter your CCN (previously the Medicare provider number) if agency is Medicare certified.

- **NPI # -** Enter your National Provider Identifier number. Health care providers such as physicians, dentists, and pharmacists, and organizations, such as hospitals, nursing homes, pharmacies, and home care companies who transmit health information electronically are required to obtain NPIs. For further information visit http://www.cms.gov/NationalProvIdentStand/

- **Agency Types**
  - **Facility Based –** Any home health agency that is owned or affiliated with a hospital, nursing facility or rehabilitation facility.

  - **Freestanding -** Any home health agency that is **not** owned or affiliated with a hospital, nursing facility or rehabilitation facility.

  - **Government Based –** Any home health agency that is County, City-County, City, or District owned or affiliated.

- **Unduplicated Intermittent Patients -** (reported on page 1, Item 1) - The number of individuals receiving **intermittent** service from an agency during the report year **counted only once, regardless of the number of services, frequency of admission, or payor source.**

- **Admissions -** [reported on page 1, Item 3(a)] - The total number of admissions during the report year regardless of the number of individuals involved. For example, the same individual admitted more than once during the reporting period would be

counted each time admitted. Multiple admissions of same patient would be included in 3a total.

- **Intermittent Visits -** Direct face-to-face contact with a client for the purpose of delivering service measured in visits regardless of length of time of the visits or payment source. Include all visits made during the report year, including visits for patients already on service at the beginning of the report year. Intermittent data is required information. Agencies must complete **all** sections of the Annual Report form.

- **Medicare PPS Patients -**Report all requested information for patients covered by regular Medicare, billed to the Medicare Fiscal Intermediary

- **Medicare Managed Care** -Report all requested information for Medicare patients covered by an approved Medicare Health Maintenance Organization (HMO) plan

ITEM-BY-ITEM INSTRUCTIONS

ITEM 1 UNDUPLICATED INTERMITTENT PATIENTS: Patients admitted during the calendar year. Enter the unduplicated intermittent patients admitted (this is equal to the number of individuals receiving **intermittent** service from an agency during the report year **counted only once**, regardless of the number of admissions, frequency of admission, number of services, or payor source to the agency from the period January 1 - December 31 of the report year.) The total of this line **will not** correspond with any other totals reported on this Annual Report. **The number of unduplicated intermittent patients must be equal or less than the intermittent admissions in Item 3a.**

ITEM 2 INTERMITTENT CENSUS ON JANUARY 1: Enter the number of patients receiving **intermittent** services at the beginning of the business day on January 1 of the report year.

ITEM 3 INTERMITTENT ADMISSION AND DISCHARGE SUMMARY

(a) Admissions: Enter the number of **intermittent** admissions - those admitted **after** the beginning of the business day on January 1 of the report year. (See definition above for "Admissions.") The number of intermittent admissions must be equal or greater than the unduplicated intermittent patients in Item 1.

(b) Discharges: Enter the number of times patients were discharged from the agency in the report year.

ITEM 4 INTERMITTENT CENSUS ON DECEMBER 31: This number will automatically be calculated. The number is derived from the following: # 2 + 3a – 3b = 4

ITEM 5 NUMBER OF MEDICARE PPS EPISODES ENDED DURING THE YEAR:
A Medicare PPS Episode is 60 days or less. Each 60-day certification period is considered an episode.

Coverage for Medicare PPS beneficiaries is covered in "episodes" of care not to exceed 60 days in duration. Enter the number of episodes ended during the reporting year, including both episodes ended due to completion of a 60 day period (patients eligible for recertification and start of a new episode during the same admission) and episodes ended due to patient discharge. Episodes in process at the beginning of the year are included, but episodes started during the year and in process at the end of the year are not included.

ITEM 6 DISPOSITION UPON DISCHARGE: Refers to the level of care to which the client was discharged upon termination of services. Self/ Family Care includes independent resources such as family and neighbors. Do not include patients who are discharged (or transferred) from one source of payment and immediately receive services under another payment source; only those discharged **from the agency** should be counted here. The total (g) will equal the total of Item 3, line (b).

ITEM 7 VISITS BY DISCIPLINE & PRINCIPAL PAYOR SOURCE: Include the number of intermittent visits made for each discipline and principal payor source listed. Include all visits, made during the report year, including visits for patients already on service at the beginning of the report year.

ITEM 8 PATIENTS BY PRIMARY DIAGNOSIS: List the number of patients according to the primary diagnosis at the time of admission to the agency. Only include admissions made after January 1 and through December 31 for the report year. The total (t) will equal the total of Item 3, line (a); Item 9, line (h) and Item 10 total admissions.

ITEM 9 PATIENTS BY AGE: List the number of patients according to age at the time of admission to the agency. Only include admissions made after January 1 and through December 31 of the report year. The age categories listed correspond with the age guidelines for the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program and other funding sources. The total (h) will equal the total of Item 3, line (a); Item 8, line (t) and Item 10 total admissions.

ITEM 10 NUMBER OF ADMISSIONS BY COUNTY: List the intermittent admissions made within each county. In the admissions columns, only include admissions made after January 1 and through December 31 of the report year. The totals at the bottom of the page will correspond as follows: intermittent total number of admissions will equal the total of Item 3, line (a); Item 8, line (t) and Item 9, line (h).

COUNTY CODES - On page 7of the Annual Report, list the county in Missouri where the parent office of the agency is located. Use the appropriate three-digit code from the list below.

001	Adair
003	Andrew
005	Atchison
007	Audrain
009	Barry
011	Barton
013	Bates
015	Benton
017	Bollinger
019	Boone
021	Buchanan
023	Butler
025	Caldwell
027	Callaway
029	Camden
031	Cape Girardeau
033	Carroll
035	Carter
037	Cass
039	Cedar
041	Chariton
043	Christian
045	Clark
047	Clay
049	Clinton
051	Cole
053	Cooper
055	Crawford
057	Dade
059	Dallas
061	Daviess
063	DeKalb
065	Dent
067	Douglas
069	Dunklin
071	Franklin
073	Gasconade
075	Gentry
077	Greene
079	Grundy
081	Harrison
083	Henry
085	Hickory
087	Holt
089	Howard
091	Howell
093	Iron
095	Jackson
097	Jasper
099	Jefferson
101	Johnson
103	Knox
105	Laclede
107	Lafayette
109	Lawrence
111	Lewis
113	Lincoln
115	Linn
117	Livingston
119	McDonald
121	Macon
123	Madison
125	Maries
127	Marion
129	Mercer
131	Miller
133	Mississippi
135	Moniteau
137	Monroe
139	Montgomery
141	Morgan
143	New Madrid
145	Newton
147	Nodaway
149	Oregon
151	Osage
153	Ozark
155	Pemiscot
157	Perry
159	Pettis
161	Phelps
163	Pike
165	Platte
167	Polk
169	Pulaski
171	Putnam
173	Ralls
175	Randolph
177	Ray
179	Reynolds
181	Ripley
183	St. Charles
185	St. Clair
187	St. Francois
189	St. Louis Co.
191	St. Louis City (510)
193	Ste. Genevieve
195	Saline
197	Schuyler
199	Scotland
201	Scott
203	Shannon
205	Shelby
207	Stoddard
209	Stone
211	Sullivan
213	Taney
215	Texas
217	Vernon
219	Warren
221	Washington
223	Wayne
225	Webster
227	Worth
229	Wright

CHECK YOUR 2010 ANNUAL REPORT TOTALS!

Avoid errors in your data reporting. Use this page as a cross-reference to be sure your section totals are correct.

NOTE: Do not include data for patients residing outside of Missouri. **Only report information for services rendered to home health patients in Missouri. (Do not include in-home or private duty services.)**

Y	***Total of This Item:***	***Should Equal the following Items:***	***Other Hints***
	1	No other sections	The number of unduplicated intermittent patients must be equal or less than the intermittent admissions in Item 3a.
	2	No other sections	Vertically: check calculations for columns. Add Item 2 plus Item 3(a) minus Item 3(b). Should equal Item 4
	3(a)	8(t); 9(h) & 10 total admissions	
	3(b)	6(g)	
	4	No other sections	
	5	No other sections	
	6(g)	3(b)	
	7(h)	No other sections	Item 7 should add correctly both vertically and horizontally.
	8(t)	3(a) total; 9(h) & 10 total admissions	
	9(h)	3(a) total; 8(t) & 10 total admissions	
	10 admissions	3(a) total; 8(t) & 9(h)	